MDR Tracking Number: M5-05-0921-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 11-18-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. The IRO determined that the office visit on 03-19-04 **was** medically necessary. The IRO determined that all other services under review **were not** medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee. The respondent raised no other reasons for denying reimbursement for the above listed services.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with Medicare program methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 03-19-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 10th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO decision

January 7, 2005

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-05-0921-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

According to the records received and reviewed, the injured employee ___ was injured in a work related injury on ___. The injured employee was working for Brownsville ISDF when she was injured. Ms. ___ slipped on an uneven sidewalk while returning from walking students to the bus area. The patient fell down to the concrete landing on both of her hands and knees. The patient also reported hitting the right side of her face on the concrete. She initially reported to the nurse's office. She subsequently reported to Dr.

Anderson's office for care. Ms. ___ later reported to Dr. Howell for care of her injuries. Ms. ___ presented to Dr. Howell for exacerbation of her injuries on ___. Ms. ___ complains of low back pain and sharp radiating pain from her low back to the bottom of her buttocks on her right. She also complains of neck pain and stiffness with a popping sensation. The patient also reported pain in her right shoulder and knee pain on the right.

Numerous treatment notes, diagnostic tests, staffing notes, evaluations, and other documentation were reviewed for this file. Specific records identified include but are not limited to the following:

Medical Dispute Records Reviewed:

EOB's from the Insurance Carrier
Medical Dispute Resolution paperwork from South Coast Spine & Rehabilitation
Medical Records from South Coast Spine & Rehabilitation
MRI Lumbar, Cervical dated 3-23-2002
MRI Right Shoulder dated 2-12-2002
MRI Left Knee, Right Knee dated 2-12-2002
MRI Right Wrist dated 3-16-2002
Report from Dr. Poulos
Report from Dr. Clark
Report from Dr. Krammer
Report from Dr. Tijimes
Report from Dr. Bassett

DISPUTED SERVICES

Disputed services include office visits (99213, 99214), massage (97124) and aquatic therapy (97113) from 3/19/04 through 8/6/04.

DECISION

The reviewer disagrees with the previous adverse decision regarding 99214 on 3-19-2004.

The reviewer agrees with the previous adverse decision regarding all other services for the dates of service under review.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, Evidenced Based Medical Guidelines, Medicare Payment Policies, and Occupational Medicine Practice Guidelines. Regarding the initial examination on 3-19-2004, Dr. Howell has the obligation to

determine the medical status of a patient under his care and to evaluate the necessity for care. This evaluation would be necessary to evaluate Ms. ___ and make the appropriate medical decision. This evaluation would include medical decision making to include the appropriateness of care, consulting with the patient, and the necessary plan of care or referral. The reviewer feels that any care after the initial evaluation with Ms. ___ would be unnecessary. Ms. ___ exceeds the normative data as established by the MDA for her injury. In fact, she is over two years post injury, which would exceed most practice guidelines for treatment of a conservative nature. It is difficult to establish if her symptoms are casually related to the injury two years prior. The treating doctor does identify the screening criteria used in his rationale for treatment, Texas Guidelines for Chiropractic Quality Assurance Practice Parameters-Chapter 8 and North American Spine Society-Initial Phase of Care. However both of these guidelines submitted refer to the initial phase of care in the acute phase. Ms. ___ is past her acute phase of injury and although the treating doctor may state that the patient is in an acute exacerbation of a chronic condition, there is not an adequate specifically identifiable incident, which caused the exacerbation that, can be clearly casually related to the initial injuries two years prior. In fact both of those sources cited report care of up to 8 weeks, which would be considered appropriate from the initial date of injury and not two years later. The treatment rendered also does not meet the medical necessity as established by TLC 408.021 in the fact that the treatment did not cure or relieve the effect from the compensable injury (due to the fact that the causality to the original injury could not be established), promotes recovery (the VAS scales as follows), or enhance the ability of the employee to return to work or retain employment (TWCC dated 3-19-2004 placed the patient at full duty and subsequent documentation does not adequately identify changes in work status). The patient has self reported Visual Analog Scales of pain at a 6 out of 10 on 3-19-2004, 6-18-2004, and 7-9-2004. This shows that the patient's pain is not being diminished by the care administered as reported by the patient. The patient also reports that the therapy has not resulted in any improvement in the 7-9-2004 evaluation, which is a significant factor. In regards to ranges of motion, the following were identified in degrees:

Cervical	3-19-2004	6-18-2004	7-8-2004	7-9-2004
Flexion	60	30	30	60
Extension	75	35	35	60
Left Rotation	45	40	42	80
Right Rotation	80	40	42	60
Left Lateral Flex	45	25	25	45
Right Lateral Flex	45	25	25	30
Lumbar				
Flexion	30	30	30	50
Extension	10	10	10	10
Left Lateral Flex	10	10	10	20
Right Lateral Flex	10	10	10	20

These ranges of motion show that the patient made little to no improvement from 3-19-2004 through 7-8-2004, which is when the treatments were being administered and then made

significant changes from 7-8-2004 to 7-9-2004 in her ranges of motion. The changes do not substantiate the care administered.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director